AN ATLAS OF REGIONAL DERMATOLOGY

An Atlas of Regional Dermatology

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Illustrated with 475 Clinical Subjects in Full Colour



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PREFACE

This Atlas is intended for use as an aid to the diagnosis of diseases of the skin. Its scope is limited to the presentation of representative examples of the common and less rare cutaneous disorders, as far as possible in their early developing and fully developed stages—and what is rare and what is common may vary with locality

Many eruptions bear a close resemblance to one another and can only be differentiated by the recognition of minute details. In an Atlas the illustrations of such eruptions can be closely approximated thus enabling the observer to contrast and compare what is similar and in so doing note minor but important points of difference. Since this arrangement is based entirely on the morphology of the eruption, it cannot be conveniently employed in systematic textbooks on Dermatology

Some skin diseases present a greater variety of eruptive elements than others, and consequently the clinical appearance of the eruption as a whole may differ to a considerable degree from case to case. Conversely diseases whose pathology and course are different may resemble each other closely as far as their skin manifestations are concerned Such conditions naturally require a larger number of illustrations than do those which are more constant or distinctive in their appearances, and this applies to the rarer diseases such as Dermatitis Herpetiformis and Pemphigus, as well as to the more common ones such as the cutaneous cancers

A regional arrangement of the Atlas has been chosen for several reasons, even if it involves some duplication According to the site affected a given eruption may show variations from what is described as its normal appearance Most skin diseases may occur on any part of the body surface, but the majority tend to be selective in the regions which they affect, even although such selectivity is seldom exclusive or uniform In the clinic most diseases of the skin present themselves as regional problems.

In conclusion the Authors have pleasure in recording their indebtedness to the University of Edinburgh for the use of the transparencies reproduced in this Atlas. They also wish to acknowledge the help given by Dr D A Duthie in connection with the clinical photography and Dr Allen Lyell in the preparation of the index.

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FIG. 1

Impetigo Contagiosa

The lesions are superficial subcorneal bullæ the contents of which have coagulated to form crusts. On the centre of the cheek crust has been removed to expose the raw base of bulla and the remains of the bulla roof are visible as scale bordering the lesion.



FIG. 2

Impetigo Contagiosa

The lesions are numerous and the crusts have coalesced.



FIG. 5

Impetigo Contagiosa

The lesions are scanty and discrete, and at first sight might suggest acne vulgaris. Their sudden onset, bullous character, and short duration serve as distinguishing features.



FIG. 6

Papulosquamous Syphilide

The lesions may bear superficial resemblance to impetigo, acne, and rosacea, but they consist of *indurated* papules, and their duration is limited to a few weeks. The details of individual lesions are show in Fig. 395



FIG. 3

Impetigo Contagiosa

The same case as in Fig. 2. The crusts have been removed revealing the oozing bases of numerous bullæ.



FIG. 4

Impetigo Contagiosa

The eruption consists of the glistening bases of numerous bullæ and crusting is not a prominent feature. The lesions tend to be circinate in places, possibly suggesting tinea circinata. [illegible] near purely bullous character is the distinguishing feature and further confirmation could be obtained by microscopic examination of epidermal tags [illegible] t the edge of the lesions.



FIG. 9

Herpes Simplex

The eruption is more extensive than usual the vesicles have become converted into crusts there is some resemblance to impetigo, but the grouping of the lesions is apparent.



Fig. 7

Herpes Simplex

The lesions consist of firm vesicles grouped in bunches. Acne lesions are present on the cheeks and chin



Fig. 8

Herpes Simplex

Herpes simplex of lip and cheek. The grouping of the firm vesicles and the limited duration of the eruption, usually five to ten days, differentiate it from impetigo. Recurrences are common, and the eruption may be bilateral.

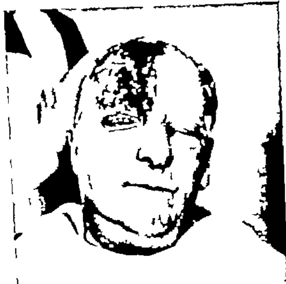


FIG. 12

Herpes Zoster

Eruption on the tenth day. It is now crusted and slightly hæmorrhagic. The upper eyelid has become affected and there is considerable œdema of the corresponding cheek.



FIG. 13

Herpes Zoster

Eruption on the fifteenth day. The crusts have been removed revealing the raw upper surface of the dermis. Healing will be completed by scar formation.



Fig. 10

Herpes Zoster

The eruption has been present for three days. It consists of firm vesicles arranged in bunches on an area of erythema. The linear and unilateral distribution is apparent



Fig. 11

Herpes Zoster

Eruption on the fifth day. It is unilateral, the vesicles, which are becoming purulent, are grouped as in herpes simplex but are more deeply situated in the skin.



Fig. 16A

Tinea Barbae (Kerion type)



Fig. 16

Tinea Barbae of Neck

In Figs. 16A, 16B indurated inflammatory nodules are prominent and distinguish the condition clinically from staphylococcal sycosis, even when secondary staphylococcal folliculitis has developed. The fungus infection is slowly eradicated, through the development of tissue immunity. The condition is thus self-healing and of limited duration. It lasts from six weeks to three months and may leave scar. In some cases its clinical appearance might suggest syphilis.



FIG. 14

Sycosis Barbæ (Staphylococcal)

As the case is an early one, pustulation is clearly seen. Later as a result of recurrent pustulation, the affected areas become persistently erythematous and slightly swollen, and in these circumstances pustules are less clearly seen.



FIG 15

Sycosis Barbæ (Staphylococcal)

Pustulation is less in evidence. Chronic congestion and slight swelling of the skin are present together with a chronic eczema reaction. The case is of long standing.



Fig. 19

Acne Vulgaris

Pustular lesions are mingled with infected sebaceous cysts.



Fig. 20

Acne Vulgaris



Fig. 17

Acne Vulgaris

The lesions are composed of blackheads (comedones) and the papules and pustules which develop at the mouths of the follicles which are plugged by them.

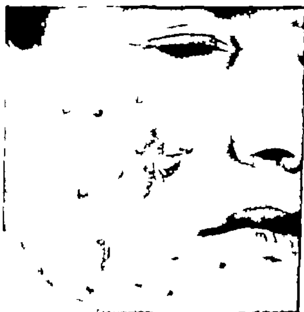


Fig. 18

Acne Vulgaris

Pustules and elongated indolent superficial abscesses are present.



FIG. 23

Rosacea

This eruption has been present for a few years and bears some resemblance to lupus erythematosus, but the eruptive elements are papules and pustules which vary in amount from eek to week.



FIG. 24

Rhinophyma

This condition may complicate rosacea or arise spontaneously. It is of slow development but permanent. It consists of hyperplasia of the sebaceous glands of the area, accompanied by an increase in the vascularity of the area. These changes manifest themselves in the form of soft tumour-like enlargement of the nose. Periodic pustulation may be troublesome feature.



Fig 21

Rosacea

The lesions consist of persistent erythema and recurrent papules which may become purulent. The papules are not preceded by blackheads, and the disease occurs rarely if ever during adolescence.



Fig 22

Rosacea

The eruptive elements come and go on the blush area, and the appearance varies from week to week. This, together with the fact that the lesions are papules and pustules, differentiates it from lupus erythematosus.



FIG. 26

Papulonecrotic Tuberculide

The lesions consist of firm papules of varying size which persist for a number of weeks and eventually become necrotic. Scar formation may accompany healing. As a result of successive eruptions of papules the condition may persist for number of months. As is seen in subsequent illustrations, the amount of the eruption may vary considerably



FIG. 27

Papulonecrotic Tuberculide

A more florid example than that shown in Fig. 26.



FIG. 25

Nodulocutaneous Syphilide

The nodular character of the eruption distinguishes it from rosacea, as does its comparatively short duration. Serological tests for syphilis are positive. The nose, particularly the alæ nasi is a not uncommon site for late secondary and early tertiary syphilitic lesions.



Fig. 30

Annular Sarcoid

This is an unusual configuration of a superficial sarcoid. The lesions consist of persistent superficial nodules arranged in annular form. The histopathology is typical. Any epidermal change is secondary to the infiltrate in the dermis, and should its presence in the form of scaling suggest tinea circinata, the absence of fungus elements in the scales will exclude the latter condition.



Fig. 31

Reticulum Cell Sarcoma

The form of the lesion is an infiltrated plaque of   goo outline and the diagnosis is only possible from the histopathology



FIG. 28

Papulonecrotic Tuberculide

The histology of the lesions is typical in this disease.



FIG. 29

Sarcoid

The lesion is an indolent, diffuse painless swelling which develops slowly and often has a violaceous colour. The diagnosis rests on the histopathology which is typical. Clinically a reticulum cell sarcoma might be considered.



Fig. 34

Adenoma Sebaceum

Case of tuberosclerosis the associated periungual fibromata are shown in Fig. 227



Fig. 35

Adenoma Sebaceum



Fig. 32

Adenoma Sebaceum

The lesions consist of small red nodules composed of *hyperplastic sebaceous glands and vessels. It is usually* associated with some degree of mental deficiency and may accompany tuberosclerosis.



Fig 33

Adenoma Sebaceum



Fig. 34

Adenoma Sebaceum

Case of tuberosclerosis: the associated periungual fibromata are shown in Fig. 227



Fig. 35

Adenoma Sebaceum



Fig. 32

Adenoma Sebaceum

The lesions consist of small red nodules composed of hyperplastic sebaceous glands and vessels. It is usually associated with some degree of mental deficiency and may accompany tuberosclerosis.



Fig 33

Adenoma Sebaceum



Fig. 38

Lupus Erythematosus

There are erythematosquamous plaques on which telangiectatic vessels are visible. The absence of recurring papules and pustules, and the stationary character of the eruption, differentiate it from rosacea.



Fig. 39

Lupus Erythematosus

There are chronic discoid plaques with thick adherent masses of keratin on the surface. Atrophic scarring is also in evidence.



FIG 36

Lupus Erythematosus

The eruption is of recent origin and consists of erythe matous plaques which are slightly raised. As in all varieties of lupus erythematosus, apple jelly nodules cannot be demonstrated by vitropression.



FIG 37

Lupus Erythematosus

The eruption consist of infilt ated discoid lesions which have a rough surface due to hyperkeratosis nd plugging of the follicle mouths by keratin.



Fig. 38

Lupus Erythematosus

There are erythematosquamous plaques on which telangiectatic vessels are visible. The absence of recurring papules and pustules, and the stationary character of the eruption, differentiate it from rosacea.



Fig. 39

Lupus Erythematosus

There are chronic discoid plaques with thick adherent masses of keratin on the surface. Atrophic scarring is also in evidence.



FIG 40

Lupus Vulgaris

This eruption is not complicated by secondary features such as scaling, crusting or ulceration. The eruption consists of a slightly swollen erythema which has a brownish tinge. Vitropression reveals "apple-jelly nodules" which differentiate it from lupus erythematosus. The absence of papules and pustules and week-to-week variation in appearance distinguish it from rosacea, and its long duration and the results of serological investigation from syphilis.



FIG 41

Lupus Vulgaris

A lesion of recent origin.



Fig. 42

Lupus Vulgaris

The clearly defined irregular margin of the plaques is evident and the brownish-red colour of the eruption is typical.



Fig. 43

Lupus Vulgaris

The eruption is composed of an aggregation of small tubercles situated in the dermis. There is some secondary scaling.



Fig. 44

Lupus Vulgaris

The disease has lasted for many years and has caused mutilation of the cartilages. The scarring, which is mingled with still active disease is due to treatment.



Fig. 45

Lupus Vulgaris



FIG. 46

Flexural Infective Eczema

Early flexural infective eczema with secondary pustulation and impetigo on surrounding skin.



FIG. 47

Flexural Infective Eczema

Early stage, showing fissuring at the depth of the fold.



Fig. 44

Lupus Vulgaris

The disease has lasted for many years and has caused mutilation of the cartilages. The scarring, which is mingled with still active disease, is due to treatment.



Fig. 45

Lupus Vulgaris



Fig. 50

Flexural Infective Eczema

Starting behind both ears as in Fig. 46, the reaction has extended to involve the whole scalp and has spread to the adjacent skin of the forehead and eyebrows.



Fig. 51

Flexural Infective Eczema

A retro-auricular flexural infective eczema which has spread to involve the scalp.



Fig. 48

Flexural Infective Eczema

To show the symmetry of the lesion on each side of the retro-auricular fold (see subsequent illustrations of other folds).



Fig. 49

Flexural Infective Eczema

The eczema reaction has spread from the retro-auricular fold to the adjacent scalp while the outer aspect of the pinna remains free



Fig. 54

Flexural Infective Eczema

Symmetrical involvement of the fold of the upper eyelid. Note the absence of oedema and compare with contact eczema on the same area.



Fig. 55

Flexural Infective Eczema

The upper and lower lids and the canthi are involved. Note the absence of oedema. The retro-auricular folds were affected first.



FIG 52

Flexural Infective Eczema

Similar case to Fig. 51 Such cases are also included in the ill-defined and indefinite group of "Seborrhoeic Eczema"

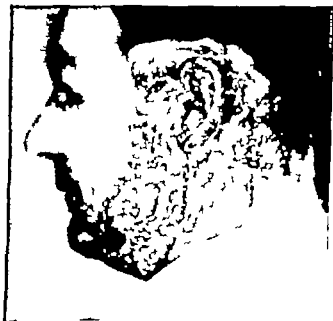


FIG 53

Flexural Infective Eczema

This case illustrates one mode of origin of flexural infective eczema. There is a primary impetigo of the *face neck, and retro-a ricular region The impetigo later* cleared under treatment lea ng in its w ke a persistent retro-auricular i fecti e eczema.



Fig. 58

Contact Eczema

The reaction has been caused by an ingredient in lipstick.

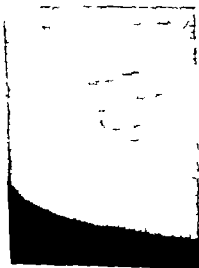


Fig. 59

Contact Eczema

Positive patch test (lipstick)



Fig. 56

Contact Eczema

The reaction is due to sensitivity to an eye lotion. Note the œdema associated with the reaction and compare with Fig. 55



Fig. 57

Contact Eczema

The reaction is due to sensitivity to atropin. Note the widespread œdema.



FIG. 62
Infantile Eczema



FIG. 63
Infantile Eczema
The eruption has developed secondary impetigo



FIG. 60

Solar Eczema

Note the distribution of the reaction on the prominences of the face and the absence of œdema of eyelids The condition m ght in some cases suggest rosacea or lupus erythematosus. Apart from the recognition that the eruption is an eczema reaction, the history of seasonal occurrence is a help n diagnosis.



FIG 61

Solar Eczema

Note the nvolvement of the lobe of ea The distribution of the sh o this area is a help m diagnosis.



Fig. 65

Acne Keloid

This shows the early chronic recurrent pustular stage. The condition is staphylococcal folliculitis. An anatomical abnormality in a number of the hair follicles on the affected area, consisting of the incorporation of several hairs in single follicle, is predisposing factor



Fig. 66

Acne Keloid

Stage of hypertrophic scar formation. I due course the recurrent folliculitis results in the development of mass of granulation tissue which destroys the hairs on the area and hich clinically resembles keloid.



FIG 64

Pityriasis Rubra Pilaris

The eruption is purely erythematous, and scaling is seldom a marked feature. The presence of the eruption on other areas may be necessary for a diagnosis. As a rule the histopathology is inconclusive as a diagnostic factor



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Fig. 66

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Stage of hypertrophic scar formation. In due course the recurrent folliculitis results in the development of mass of granulation tissue which destroys the hairs on the area and such clinically resembles keloid.



FIG. 64

Pityriasis Rubra Pilaris

The eruption is purely erythematous, and scaling is seldom a marked feature. The presence of the eruption on other areas may be necessary for a diagnosis. As a rule the histopathology is inconclusive as a diagnostic factor



Fig. 69

Lichen Simplex

This is sequel to patch of post-traumatic infective eczema. The skin is thickened and of leathery texture. The term neurodermatitis is also applied to such localised thickened patches.



Fig. 70

Tinea Corporis



Fig. 67

Acne Keloid

Stage of atrophy. The keloid-like mass eventually resolves itself and gives place to an atrophic scar.



Fig. 68

Xanthoma

Eruption of xanthomata in a case of xanthoma tuberosum. The lesions appear as firm yellowish nodules of varying size. These persist for a variable period and then disappear. They tend to erupt in successive crops, so that the eruption as a whole may be of long duration.



FIG. 73

Hyperkeratotic Nevus

The structure of this birthmark is hypertrophy of the stratum corneum. Lesions of this type are almost always linear and may cover large areas.



FIG. 74

Mixed Hyperkeratotic Nevus and Nevus Sebaceus

There is congenital hypertrophy of the stratum corneum and the sebaceous glands. A linear pattern is usual.



FIG. 71

Fixed Drug Eruption

A recurrent erythema which in an individual case always occurs on the same site. In this patient it is caused by phenolphthalein.

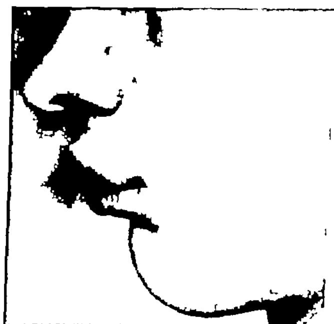


FIG. 72

Erysipeloid

Chronic recurring erysipelatous eruption (erysipelatoid). The condition is affecting the cheek and upper lip. It resembles erysipelas but systemic symptoms are absent. The condition is recurrent and the affected areas become somewhat thickened, presumably result of blockage in the cutaneous lymphatic plexus.



Fig. 77

Nevus Sebaceus

In this case the lesions are single and do not show the usual linear pattern. The diagnosis can be made only by histological examination.



Fig. 78

Nevus Sebaceus



FIG. 75

Nævus Syringadenomatosus Papilliferus

In this tumour the hypertrophy is limited to the sweat glands and their ducts. The surface is frequently eroded in places, giving the impression of granulation tissue.

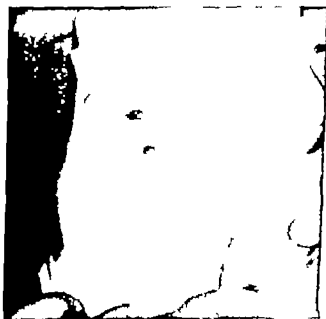


FIG. 76

Nævus Sebaceus

Nævi of the type shown in Figs. 75 and 76 can only be differentiated histologically



Fig. 77

Naevus Sebaceus

In this case the lesions are single and do not show the usual linear pattern. The diagnosis can be made only by histological examination.



Fig. 78

Naevus Sebaceus



FIG 79

Naevus Syringadenomatosus Papilliferus

This naevus may present an eroded surface. Histological examination is necessary to distinguish accurately between it and the preceding naevus.



Fig. 30

Diffuse Alopecia (Post-febrile type)

In this case the fall of hair took place about six weeks after recovery from pneumonia. Regrowth is the rule.



Fig. 31

Diffuse Alopecia (Syphilitic type)

The occipital region usually best shows the incomplete alopecia of secondary syphilis.



FIG 82

Circumscribed Alopecia (Alopecia Areata)

The clean shiny surface of the bald area is characteristic of the disease and differentiates it from tinea capitis.



FIG 83

Circumscribed Alopecia (Pseudopelade of Brocq)

Note the irregular pattern this form of alopecia is permanent, and it develops and spreads slowly



Fig. 84

Circumscribed Alopecia (Folliculitis Decalvans)

The scanty pustulation is in evidence. It slowly produces a cicatrix with permanent loss of hair



Fig. 85

Circumscribed Alopecia (Folliculitis Decalvans)

The pustulation is profuse, resembling sycosis.



Fig. 82

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Fig. 83

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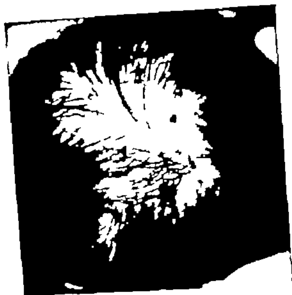


Fig. 84
Circumscribed Alopecia (Folliculitis Decalvans)
The scanty pustulation is in evidence. It slowly produces cicatrix with permanent loss of hair



Fig. 85
Circumscribed Alopecia (Folliculitis Decalvans)
The pustulation is profuse, resembling sycosis.



Fig 86

Circumscribed Alopecia (Lupus Erythematosus)

Active erythematous areas are to be seen and these and the atrophic scars which result from them cause permanent destruction of the follicles.

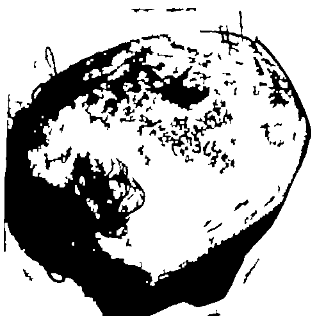


Fig 87

Circumscribed Alopecia (Syphilitic)

A gummatous syphilide which has produced extensive cicatrisation and permanent loss of hair



Fig. 88

Tinea Capitis

The partially bald patch is covered with thick matting of scales, and short broken and twisted hairs are present on the surface. This contrasts with the smooth clean bald patches of alopecia areata. Examination of the patient under Wood' light and microscopic examination of hairs should be carried out



Fig. 89

Tinea Kerion

The reaction to the fungus invasion is more definite in this case and pustulation is present. This is commencing kerion hich became fully developed in the succeeding week.



Fig. 90

Tinea Kerion

This shows a small well-developed kerion of the scalp. The appearance suggests that of an aggregation of small cutaneous abscesses.



Fig. 91

Favus Capitis

The hairs are matted with dry squamæ crusts, an appearance liable to be mistaken for impetigo or eczema.



Fig. 92

Favus Capitis

The scalp is covered with friable squamous crusts, and completely bald atrophic areas are to be seen.



Fig. 93

Favus Capitis

The greater part of the scalp has become atrophic and permanently denuded of hair. Masses of adherent friable squamous crusts are present and few isolated cup-shaped scutula are to be seen.

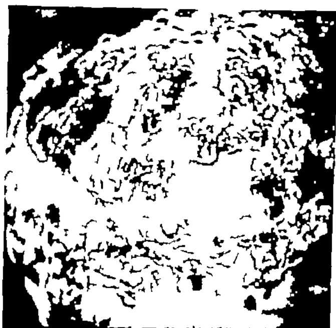


FIG. 94

Favus Capitis

The crusting is composed of fungus elements and desiccated exudate. Permanent cicatricial baldness is present.



FIG. 95

Favus Capitis

As in the preceding examples scutula, massive crusting, scarring, and alopecia are present



FIG. 96

Vitiligo

The skin texture is normal and the change consists in the loss of the capacity to form pigment in certain areas. The adjacent areas are often hyperpigmented.



FIG. 97

Senile Elastosis

The skin is yellowish in colour hypertrophied, and the natural folds exaggerated. This is normal occurrence on exposed areas, and is due to chemical changes in the collagen bundles of the dermis.



FIG 98

Scleroderma

In addition to being sclerosed the affected area is depigmented. In some cases, particularly in the later stages when atrophy may have succeeded sclerosis, the appearance may suggest lichen sclerosus et atrophicans, and a histological examination may be necessary to establish a diagnosis. The hard texture of scleroderma serves to differentiate it from vitiligo. *In calcinosis cutis the lesions are stony hard.*



FIG. 99

Poikiloderma (Atrophicans Vasculare)

This is a slowly progressive atrophy associated with the development of telangiectasia, irregular hyperpigmentation and the whitish area of atrophic skin. It is not preceded by any inflammatory eruption. It may resemble the changes seen in long-standing lupus erythematosus, and a somewhat similar *change may be present in dermatomyositis.*



FIG. 100

Accidental Tattooing



Fig 98

Scleroderma

In addition to being sclerosed the affected area is depigmented. In some cases, particularly in the later stages when atrophy may have succeeded sclerosis, the appearance may suggest lichen sclerosus et atrophicans, and a histological examination may be necessary to establish a diagnosis. The hard texture of scleroderma serves to differentiate it from vitiligo In calcinosis cutis the lesions are stony hard



Fig 99

Poikiloderma (Atrophicans Vasculare)

This is a slowly progressive atrophy associated with the development of telangiectasia, irregular hyperpigmentation and thin whitish areas of atrophic skin It is not preceded by any inflammatory eruption It may resemble the changes seen in *long-standing* lupus erythematosus, and a somewhat similar change may be present in dermatomyositis.



FIG. 103
Capillary Angioma
Spider naevus type



FIG. 104
Capillary Angioma
Port-wine stain variety



Fig. 101
Fibroma



Fig. 102
Mixed Cell Nævus
The lesion consists of nævus cells, hair follicles, and sweat glands and ducts. This type of tumour may appear for the first time, or enlarge, about the menopause



Fig. 103
Capillary Angioma
Spider naevus type.



Fig. 104
Capillary Angioma
Port-wine stain variety



FIG 105
Capillary Angioma
" Port-wine stain " variety



FIG 106
Cavernous Angioma
The lesions of the forehead are superficial, that on the lid is superimposed on a deeper seated cavernous angioma.



FIG. 107
Verruca Filiformis



FIG. 108
Xanthelasma



Fig 109
Acneiform Nævus and Sebaceous Cyst



Fig. 110

Milium

The lesions are keratin-containing epidermoid cysts which can be shelled out with ease. They are of common occurrence in middle age. See colloid pseudomilium.



Fig. 111

Milium

Many are infected and becoming pustular



FIG 116

Cutaneous Horn and Squamous Cell Carcinoma

This lesion is an extension of the preceding one the hypertrophied epidermis at the base of the horn having developed malignant tendencies.



FIG 117

Squamous Cell Carcinoma

Microscopic examination is necessary for the correct diagnosis of cutaneous carcinomata In early cases the clinical features are not sufficiently well defined to differentiate between the two types The succeeding examples of the varying appearances which the two types may present illustrate this point



Fig. 118

Basal Cell Carcinoma



Fig. 119

Squamous Cell Carcinoma

This has developed on an X ray scar produced in the treatment of a patch of lupus vulgaris. Active lupus is still present on the lobe of the ear.



FIG 116

Cutaneous Horn and Squamous Cell Carcinoma

This lesion is an extension of the preceding one the hypertrophied epidermis at the base of the horn having developed malignant tendencies.



FIG 117

Squamous Cell Carcinoma

Microscopic examination is necessary for the correct diagnosis of cutaneous carcinomata. In early cases the cl ical features are not sufficiently well defined to d fferentiate between the two types The succeed g examples of the ying appearances which the two types may present illustrate this poi t



FIG. 122

Squamous Cell Carcinoma

This has developed on patch of lupus vulgaris.



Fig. 120

Squamous Cell Carcinoma

This has developed on an extensive area of lupus, previously treated by X-rays.

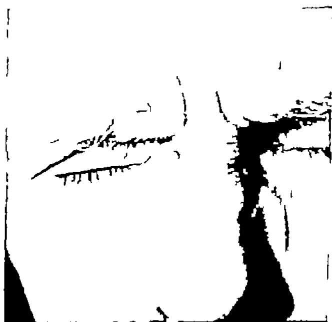


Fig. 121

Basal Cell Carcinoma

Cylindroma type.



FIG. 124
Basal Cell Carcinoma
Cylindroma type.



FIG. 125
Multiple Basal Cell Carcinomata



Fig. 123

Squamous Cell Carcinoma

The same patient after treatment with X-rays.



FIG. 128
Basal Cell Carcinoma



FIG. 129
Squamous Cell Carcinoma



Fig. 126
Squamous Cell Carcinoma



Fig. 127
Cystic Basal Cell Carcinoma



Fig. 131

Xeroderma Pigmentosum

This shows the atrophy which is partly associated with the skin condition and partly due to the treatment of numerous carcinomata. The patient is aged twenty-four and the condition was first noticed at the age of four years.



FIG 130
Basal Cell Carcinoma



Fig. 134

Leukaemia Cutis



Fig. 135

Mycosis Fungoides

The eruption bears some clinical resemblance to nodulocutaneous syphilide, and the diagnosis is determined by the histopathology and serology

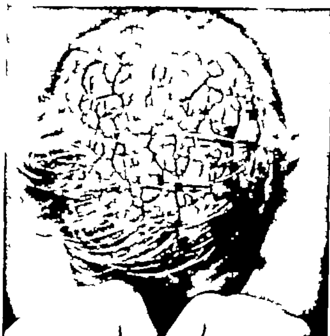


FIG 132

Sarcoma

The tumours are producing the appearance of a partial "turban tumour" Multiple basal cell carcinomata of the cylindroma type may show a similar clinical appearance.



FIG 133

Sarcoma

The eyelids and scalp are affected.



FIG. 138
Melanoma
Melanoma with malignant area in the centre.



FIG. 139
Malignant Melanoma



Fig 136

Mycosis Fungoides

In this example the infiltrate of reticulum cells does not extend deeply into the dermis, so that the lesion is not markedly tumour-like. The surface is eroded, and at first glance the condition bears some resemblance to an eczema reaction.

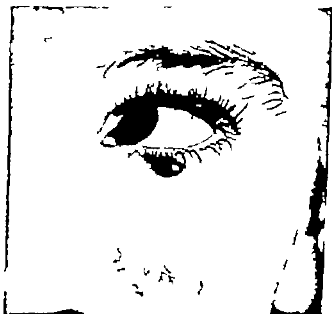


Fig 137

Malignant Melanoma

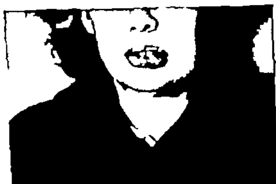


Fig. 142

Syphilitic Chancre

The lower lip is affected. Note the marked swelling of the tissues associated with the ulcer



Fig. 143

Syphilitic Chancre

Lower lip. There is commencing papulosquamous eruption on the chin.



Fig 140

Blue Naevus

This is a benign melanoma in which the pigment-forming and pigment-containing cells are situated deep in the dermis



Fig 141

Halo Naevus

A small benign melanoma with depigmentation in the surrounding skin.



FIG. 142

Syphilitic Chancre

The lower lip is affected. Note the marked swelling of the tissues associated with the ulcer



FIG. 143

Syphilitic Chancre

Lower lip. There is commencing papulosquamous eruption on the chin.



FIG 144

Lichen Planus

The lesions consist of papules which are identical with those which occur on the skin. The white appearance on the mucous membrane is due to the formation of a stratum granulosum and corneum, structures which are not normally present in the epithelium of the mucous membranes.



FIG 145

Lichen Planus

The network pattern is commonly seen. Lichen planus may affect the mucous membrane alone the skin remaining free from lesions.



Fig. 146

Lichen Planus

Isolated blue papules are visible on the mucous membrane of the cheek.

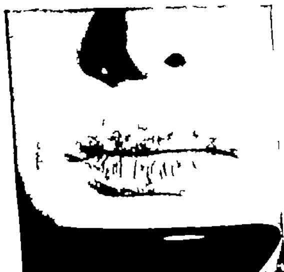


Fig. 147

Lupus Erythematosus

The eruption consists of redness and adherent scaling of the lips. It may occur on the lips alone, unaccompanied by cutaneous lesions, and in these circumstances the



FIG 148

Leukoplakia

Small retrocommisural patches of leukoplakia are common. As in lichen planus, the white appearance is due to hyperkeratosis developing on the mucous membrane epithelium. In leukoplakia the change is not limited to the surface of papules but occurs as a diffuse plaque.



FIG 149

Leukoplakia

The hyperkeratosis is marked and the area is already showing malignant change.



Fig. 150
Leukoplakia



Fig. 151
Leukoplakia

6



Fig 152

Contact Eczema

Note the large single area affected the presence of formed vesicles, and the gradual fading of the reaction at the periphery without any defined edge



Fig 153

Contact Eczema

Note the large a involved by the eruption, the lack of any demarcation at it edge and its vesicular character The thick tratum corneum of the palm holds the initial crop of esicles ntact for a longer period than would be the case on other parts of the body On the fingers the corneum forming the oof of numerous vesicles has been removed, reveal g the upper surface of the rete mucosum and, incidentally causing the eruption to become much edd in appearance



Fig. 154

Post-traumatic Infective Eczema

Note the clearly defined edges of the individual lesions in the shape of circles or segments of circle and the multiplicity of lesions in close approximation. Exudation is apparent and is proceeding from vesicles which are now forming in an epidermis denuded of its stratum corneum as result of previous crops of vesicles Compare the contour of the individual lesions with those of contact eczema.



Fig. 155

Post-traumatic Infective Eczema

Note the clearly defined margin of the eruption and the close proximity of adjacent patches.



Fig 15

Contact Eczema

Note the large single area affected, the presence of formed vesicles, and the gradual fading of the reaction at the periphery without any defined edge



Fig 153

Contact Eczema

Note the large area in olved by the eruption the lack of any demarcation at its edge and its vesicular character The thick stratum corneum of the palm holds the in tial crop of esicles intact for a longer period tha would be the case on other parts of the body On the fingers the corneum forming the roofs of numerous vesicles has been removed reveal g the upper rface of the rete mucosum and, incidentally causing the eruption to become much redde in appearance



Fig. 158

Eczema

This shows the effect of crude gas tar on the eczema reaction. The tar has been easily rubbed *off the areas previously* affected by the eczema reaction and they are clearly outlined by the medicament. This indicates that although the patches appear to be healed, the corneum is not yet completely restored to normal.



Fig. 159

Flexural Infective Eczema

A flexural infective eczema of the elbow fold with chemical eczema on the upper arm due to the application



Fig 156

Post-traumatic Infective Eczema

Note the clearly-defined edge of lesions and compare with contact eczema.

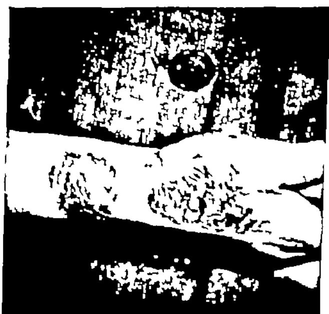


Fig 157

Post-traumatic Infective Eczema

The eruption is in a scaly phase. It bears some superficial resemblance to psoriasis, but in the latter the scales are large and laminated whereas in eczema they are small and bran-like in character



FIG. 162

Pityriasis Lichenoides

The lesions erupt as firm rounded papules which become scaly and have some resemblance to guttate psoriasis and lichen planus. Some may become pustular and leave punctate scarring. They continue to erupt over long period.

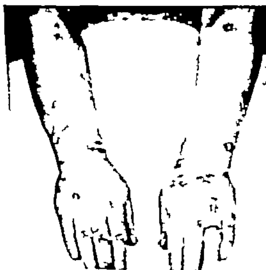


FIG. 163

Erythema Multiforme

The lesions consist of circumscribed circular infiltrated erythematous plaques which may develop bullæ in the centre. Individual lesions persist for seven to ten days and the eruption lasts for about fortnight. Similar lesions are frequently present on the back of the feet, the lips, and the back of the neck.



Fig. 160

Eczema

This shows a patch of infective eczema surrounded by secondary staphylococcal pustulation.



Fig. 161

Pustular Bacterid

The lesions are vesicopustules, but the contents are sterile. They tend to erupt over a long period. The histopathology is distinctive.

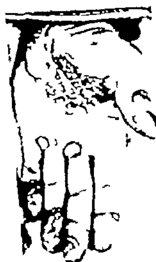




Fig. 166 | Fig. 166

Psoriasis

Fig. 166 A.—The lesions are fully developed and show typical psoriasis scaling.
Fig. 166 —The lesions have developed beneath the stratum corneum and no scaling is as yet apparent.



Fig. 167

Lupus Erythematosus

The eruption consists of telangiectatic erythema th slight scaling and there is an associated atrophy of the skin. The absence of   vesicular phase distinguishes it from an eczema reaction the presence of some degree of cutaneous atrophy and the absence of large wax-like scales, from psoriasis.



Fig. 164

Psoriasis

The lesions consist of erythematosquamous plaques, the scales are large, wax like, and heaped up on the surface in laminated layers. It may be necessary to scratch the surface to demonstrate these characters.



Fig. 165

Arthropathic Psoriasis

The nails are involved by the eruption. Waxy scaling could be demonstrated by scratching the surface of the lesions.



Fig. 170

Atrophic Lichen Planus

This is a rare form of lichen planus in which the customary aggregation of elevated flat papules is converted into an atrophic plaque. It has to be differentiated from the late stages of scleroderma and from lichen sclerosus et atrophicus. The diagnosis depends on the histopathology.



Fig. 171

Lichen Planus

The eruption consists of isolated and aggregated flat papules which are not scaly on the surface.

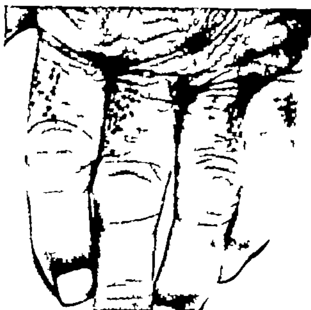


FIG 168

Pityriasis Rubra Pilaris

There is redness and slight scaling of the entire skin surface of the backs of the hands. The diagnostic feature is the presence of black horny plugs in the orifices of the hair follicles on the dorsum of the first phalanx.

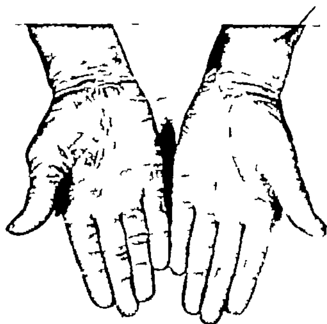


FIG 169

Pityriasis Rubra Pilaris

There is slight hyperkeratosis with scaling. It differs from traumatic, post eczematous, and climacteric hyperkeratosis by the even formation of the excess keratin. Lesions are usually present on other areas, but the appearance is so characteristic that once it has been appreciated it is usually possible to make a diagnosis even when the palms alone are affected



FIG. 174

Hyperkeratosis

Localized traumatic hyperkeratosis due to irregular cornification. This localized form often appears to arise spontaneously and is seen in middle and later life.



FIG. 175

Keratoderma Climactericum

This is a mild case which somewhat resembles the lesion in tinea palmaris. It is usually symmetrical, affecting both palms, the soles, and often the knees.



Fig. 172

Tinea Palmaris

The fungus has invaded the stratum corneum causing scale formation. This when removed reveals the glistening upper surface of the rete mucosum in the form of a sharply defined pink area bounded by a ribbon of scale. The condition may from time to time develop an eczema reaction.



Fig. 173

Traumatic Hyperkeratosis

This condition may follow the eczema reaction or arise spontaneously as a result of wear and tear causing the irregular formation of the stratum corneum.



Fig. 178

Nodulocutaneous Syphilide

The lesion consists of an aggregation of rounded nodules. It is unilateral and differs from lichen planus in which there are flat angled papules. It might suggest necrobiosis lipoidica, and could be differentiated by histopathology and serology.



Fig. 179

Scabies

Isolated vesicles, purulent crusts, and small patches of eczema, due to the presence of the acarus and to scratching.



Fig 176

Lichen Planus

Individual papules can be distinguished even in the plaque on the front of the wrist. The milky white spots and striæ on the surface of the lesions are a common feature and are due to the irregular thickening of the stratum granulosum.



Fig 177

Lichen Planus

The lesion consists of an aggregation of flat non-scaly lichen planus papules. The surface is shiny due to stretching. The absence of laminated scaling and evidence of vesiculation distinguishes it from psoriasis and a eczema reaction. Typical isolated papules are usually to be found at the edges of the plaque



FIG. 182

Psoriasis

The nail bed is affected and the nails are raised from it by the scaly lesions of psoriasis. The detached nail plates become friable and fragmented. In the absence of body lesions tinea unguium might be suspected, and could be excluded by microscopic examination of scales and nail fragments.



FIG. 183

Ringworm of the Nails

The distal portions of the nail plates have become invaded by the fungus growth and have become fragmented.

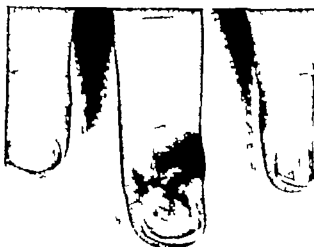


Fig. 180

Perionychia

This shows an acute early lesion

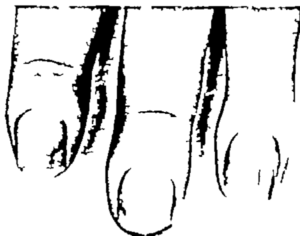


Fig. 181

Perionychia

Here the infection has been present for some time. Note the absence of the cuticle from the affected nails.



FIG. 186

Epidermolysis Bullosa

Traumatic subepidermal bullae are present on pressure points, and the skin is atrophied in places as result of previous lesions.



FIG. 187

Epidermolysis Bullosa

T show the dental malformation frequently seen in this condition.



FIG. 184

Necrobiosis Lipoidica

The lesions resemble those of granuloma annulare, but show mild inflammation and yellowish coloration in places. They consist of flat nodules and plaques. Ulceration may occur. The histopathology is characteristic. The majority of cases occur in diabetic subjects.



FIG. 185

Granuloma Annulare

The lesions consist of pale pink or ivory-like nodules arranged in an annular formation. Compare necrobiosis lipoidica, from which it can be differentiated by histopathology.



Fig. 186

Epidermolysis Bullosa

Traumatic subepidermal bullae are present on pressure points, and the skin is atrophied in places as result of previous lesions



Fig. 187

Epidermolysis Bullosa

T shows the dental malformation frequently seen in this condition.



Fig. 184

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Fig. 185

Granuloma Annulare

The lesions consist of pale pink or ivory-like nodules arranged in an annular formation. Compare necrobiosis lipoidica, from which it can be differentiated by histopathology.



Fig. 190

Xanthoma

The natural folds of the palm show yellow streaks due to fat deposit.



Fig. 188

Dermatomyositis

There is streaked telangiectatic erythema, hypertrophy of the skin of the knuckles, and wasting of the interosseous muscles.



Fig. 189

Scleroderma

The skin is hard and shiny and movement is restricted.



FIG. 193

Milkers' Nodes

The lesions are due to infection from cows' udders, probably with cowpox virus.

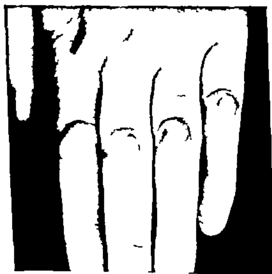


FIG. 194

Fibrochondroma

This is pure benign tumour formation affecting the knuckle pads.



FIG 191
Verruca Vulgaris



FIG 192
Verruca Vulgaris



FIG. 197

Orf

This is due to virus infection contracted from sheep suffering from pustular dermatitis in the neighbourhood of the hooves. The lesion commences as an oedematous dermic infiltrate producing an inflammatory nodule. A flaccid bulla develops on the surface of the lesion.

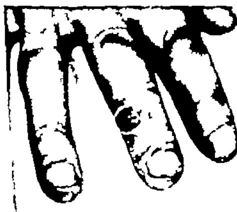


FIG. 198

Orf

The condition commences as an oedematous infiltrate producing an inflammatory nodule. A flaccid bulla develops on its surface and eventually granulating area is exposed.



Fig. 195

Granuloma Pyogenicum

The lesion consists of granulation tissue and develops at the site of a puncture wound. Compare orf and melanoma.



Fig. 196

Malignant Melanoma



Fig. 201

Diphtheritic Ulceration

Bacteriological examination of material from the surface and edge of the lesion is necessary to establish diagnosis. Systemic symptoms may develop.



Fig. 202

Blastomycosis

This rare form of fungus infection which produces chronic ulcerative granuloma. Compare tuberculosis and Bowen disease. The causative organism (blastomyces) can be demonstrated on culture and in histological sections of tissue.



Fig 199

Kerion

The lesion is a granuloma of short duration which develops as a result of animal ringworm infection.



Fig 200

Leishmaniasis

Compare carcinoma and nodulocutaneous syphilide. A diagnosis is made from the microscopic finding of Leishman Donovan bodies in serum and tissue obtained from the edge of the lesion.



Fig. 205

Bowen's Disease

The lesion results from disorganisation of epidermal growth which represents form of intra-epidermal tumour formation. In due course the change may in some cases, resolve itself int squamous cell carcinoma. The histopathology is necessary for diagnosis.



Fig. 206

Atrophy

This condition of atrophy associated ith thinning of the skin (telangiectasia), and the development of hyperkeratotic points (keratoma), usually results from prolonged exposure to sunlight and hydrocarbon derivatives.



Fig. 203

Tuberculosis Verrucosa Cutis

This form is due to external inoculation of the tubercle bacillus in an individual already sensitised to it. The reaction differs from that in lupus vulgaris by the marked hyperkeratosis which develops on the surface.



Fig. 204

Tuberculosis Verrucosa Cutis



FIG 209

Squamous Cell Carcinoma

In this case no precarcinomatous lesions had been noted.

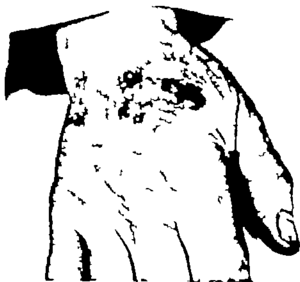


Fig. 207

Keratoma

The lesions in this case are due to prolonged contact with hydrocarbon derivatives and are closely allied to cutaneous horns. Malignant degeneration is prone to occur

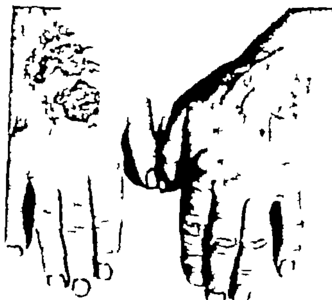


Fig 208

Keratoma and Carcinoma

The keratomata in this case are due to prolonged contact with shale oil, nd on one hand several squamous cell carcinomata have developed from the hyperkeratotic lesions.



Fig. 212

Glomus Tumour

This is a painful angioma which develops in adult life from the glomus tissue of the peripheral terminal vessels. It almost always occurs on the fingers or toes.



Fig. 213

Calcinosis Cutis

Varying sized deposits of calcium salts develop slowly in the dermis and subcutaneous tissue. Ulceration of the overlying skin and extrusion of the deposit may occur. The condition may accompany scleroderma.



FIG 210

Myxœmatous Cyst

These cysts contain a clear jelly-like liqu d They occur in the neighbourhood of the terminal phalanges, usually of the fingers. The cysts have no endothelial lining. In some cases they have been thought to communicate with the joint cavity



FIG. 211

Myxœmatous Cyst



Fig. 216

Eczema

Contact eczema of the foot. The eczematous skin has become bullous. The original vesicles can be seen as brownish points scattered over the bulla. The latter is subepidermal.



Fig. 217

Impetigo

The bullous character of the impetigo is evident because of the thick stratum corneum on the sole. A similar appearance can be produced by syphilis in the newborn.



FIG. 214

Supernumerary Digit

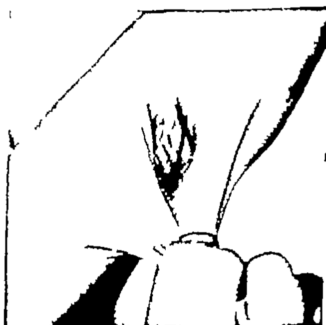


FIG. 215

Ehlers-Danlos Syndrome

The extreme elasticity of the skin is shown, and also one of the lipomatous tumours which are commonly present in the region of the joints.



FIG. 220

Eczema

An infective (pyogenic) eczema of the toes. A similar appearance could be produced by fungus infection (tinea pedis), and microscopic examination of scales and vesicle roofs is necessary to exclude this.



FIG. 221

Psoriasis

The nails and periungual skin are affected.

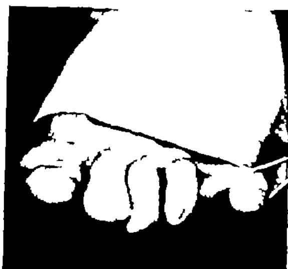


Fig. 218

Tinea Pedis

The skin in the fourth interspace is sodden, due to the growth of a fungus.



Fig 19

Eczema

Flexural infective eczema of the toes. The appearance in Figs. 219 and 220 can be produced a result of a fungus infection or an nfection by pyogenic organisms following trauma or fissuring. Microscopic examination of scales and the roofs of esicles is necessary procedure in diagnosis.



FIG. 224

Keratoderma Climactericum

The condition also occurs on the palms and knees.

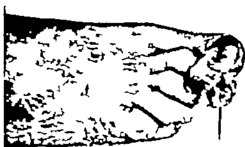


FIG. 225

Eczema

Post-traumatic infective eczema in dry scaly state.
The nails show onychogryphosis.



FIG 222

Psoriasis



FIG 223

Keratoderma Blennorrhagicum (Reiter disease)

The lesions resemble those of psoriasis but are much more heaped up on the surface, and other symptoms of Reiter's disease are present



FIG. 228

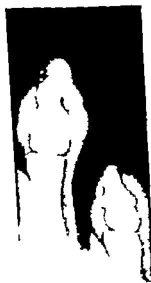


FIG. 228 a.

Subungual Exostosis

The cutaneous lesion consists of mass of granulation tissue in the region of the tip of the nail (Fig. 228). It develops as result of pressure due to an exostosis on the terminal phalanx (Fig. 228).



Fig. 226

Verruca Plantaris

The lesions are compressed *into the substance of the skin* and surrounded by a callosity. The surface of the verruca is rough, and small black dots are frequently to be seen scattered over it. The lesion may have to be differentiated from a localised hyperkeratosis or a corn.



Fig. 227

Tuberose Sclerosis

Multiple fibromata in the region of the nails. This condition may accompany that of adenoma sebaceum.



FIG. 231

Eczema

Post-traumatic infective eczema of leg showing multiple circinate patches in close apposition. The stage of vesiculation has passed and the patches show eczema pits which are oozing droplets of plasma.



FIG. 23?

Eczema

Post-traumatic infective eczema of the leg in dry scaly stage. (Compare the appearance of the reaction as shown in Fig. 242.)



Fig 229

Contact Eczema

Note the single large patches with an indefinite edge. The eruption is primarily vesicular but secondary subepidermal bullæ have developed.



Fig 230

Eczema

Contact eczema of leg showing vesiculation and secondary bulla formation The margin is indefinite In parts the epidermis forming the roofs of the vesicles has been exfoliated, revealing the bases of vesicles (eczema pits).



FIG. 235
Staphylococcal Folliculitis



FIG. 236
Pyodermia

Folliculitis and impetigo of the lower third of the leg. This state may be the precursor of an infective eczema.



FIG 233

Eczema

A large patch of post-traumatic infective eczema formed by the coalescence of several small patches. The reaction is in the dry scaly stage and resembles psoriasis.

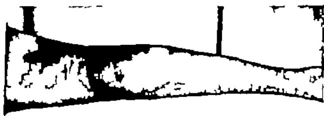




FIG. 234

Eczema

A flexural infective eczema behind the knee which has



Fɪɢ. 235

Staphylococcal Folliculitis



Fɪɢ. 236

Pyoderma

Folliculitis and impetigo of the lower third of the leg. This state may be the precursor of an infective eczema.

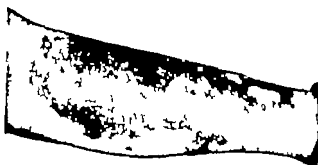


FIG. 233

Eczema

A large patch of post traumatic infective eczema formed by the coalescence of several small patches. The reaction is in the dry scaly stage and resembles psoriasis.





FIG. 234

Eczema

A flexural infective eczema behind the knee which has



Fig. 239

Eczema

The right leg is affected by post-traumatic infective eczema and the exudate has formed crust which masks the reaction. The left leg shows petechial varicose hæmorrhages but no eczema.



Fig. 240

Eczema

The same case as in Fig. 239. The secondary crusting has been removed from the right leg, showing vesicular



FIG 237

Eczema

A patch of infective eczema on the leg. There is also pustulation, and the eczema has probably arisen from the pustules.



FIG 238

Dermatitis Gangrenosa

This is a chronic deep-seated pyodermia usually associated with general debility



FIG. 243

Eczema

An infective eczema of the leg showing crackled appearance. This appearance of the eczema reaction is seen almost exclusively on the legs in middle age and after particularly in males.



FIG. 44

Dermatitis Autophytica

A simple non-eczematous dermatitis due to the application of strong dettol.



FIG. 41

Eczema

A more detailed view of the right leg shown in the previous illustration. The intense redness is in part due to vasodilatation and in part to a loss of the stratum corneum.



FIG. 42

Eczema

A close up of the right leg in Fig. 41 to show the eczema pits.

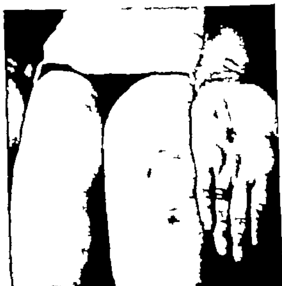


Fig. 246

Keratoderma Climactericum

The lesions affect the fronts of the knees and the palms. They consist of hyperkeratotic plaques and are to be distinguished from the scaly lesions of psoriasis



Fig. 47

Psoriasis

There much scaling on the knees, but it is minimal on the hands and arms, due to frequent washing.



Fig. 245

Eczema

A patch of lichenified eczema (neurodermatitis or lichen simplex)

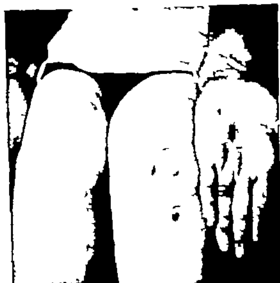


FIG. 246

Keratoderma Climactericum

The lesions affect the fronts of the knees and the palms. They consist of hyperkeratotic plaques and are to be distinguished from the scaly lesions of psoriasis.

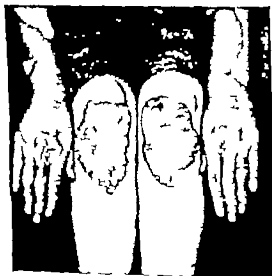


FIG. 247

Psoriasis

There is much scaling on the knees, but it is minimal on the hands and arms, due to frequent washing.



FIG 45

Eczema

A patch of lichenified eczema (neurodermatitis or lichen simplex).



Fig. 230

Purpura



Fig. 231

Majocchi's Disease

A telangiectatic and purpuric eruption which is probably angiomatous in character and which is of slow development and long duration.

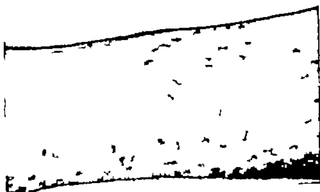


Fig 248

Purpura

A mild eruption of post-influenzal purpura affecting the leg.

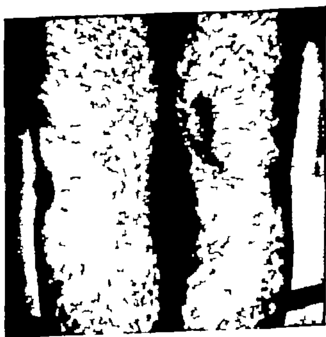


Fig. 249

Purpura

The eruption does not blanch on vitropression.



Fig. 254
Tinea Corporis
(Tinea circinata type.)



Fig. 255
Tinea Corporis
("Dhobi itch" type.)



Fig 252
Herpes Zoster
The eruption is profuse and consists of groups of vesicles.



Fig 253
Epidermolysis Bullosa
A traumatic subepidermal bulla is present and the adjacent skin shows atrophic scarring, due to previous lesions.

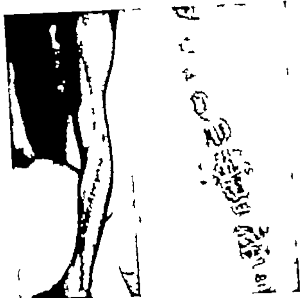


Fig 257

Psoriasis

In this case the eruption is linear in character resembling hyperkeratotic naevus. The lesions are erythematosquamous, and light scraping of the surface show the wax-like scales in the illustration on the right.



Fig 258

Pityriasis Rubra Pilaris

The eruption, which usually consists of small follicular papules, has become confluent and forms erythematous plaques which have dry rough surface. There are still islands of almost unaffected skin on which isolated papules can be seen. The eruption might suggest psoriasis or lichen planus, but waxy scales are absent and there is no infiltration such as is seen in confluent lichen planus.



FIG. 56

✓ Erythema Multiforme

Showing an annular appearance.



Fig. 261

Lichen Planus

The individual groups of papules have developed a arty surface.



Fig. 262

✓ **Molluscum Contagiosum**

The inner aspect thigh is a common site. In this case there is superficial resemblance to xanthoma, but the lobulated interior of the lesions can easily be expressed.



Fig. 259

Lichen Planus

In this case the process of aggregation of papules has gone further than in other examples and warty nodules have been formed (lichen nodularis, lichen obtusus). *The diagnosis would depend largely on the recognition of isolated* typical papules in the neighbourhood of the nodules.

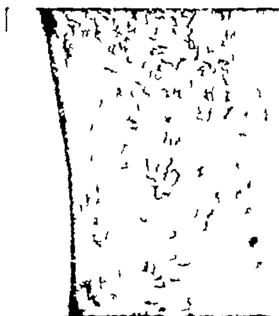


Fig. 260

Lichen Planus

A chronic eruption on the leg. The papules, where single, are larger than usual but maintain their flat shiny appearance. A warty surface has developed *in places on aggregations of papules.*



Fig. 265

Necrobiosis Lipoidica

The eruption consists of reddish brown nodules which become aggregated to form plaques of varying shapes and sizes. In contradistinction to xanthoma there may be some scaling and ulceration may develop. Diabetes is present in the majority of cases.



Fig. 266

Necrobiosis Lipoidica

The lesions commonly affect the leg and are not infrequently linear. They may bear some resemblance to psoriasis, but they are indurated. The histopathology is diagnostic.

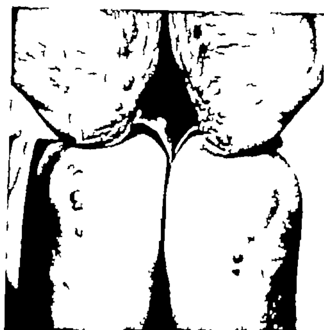


Fig. 263

Xanthoma Tuberosum

The elbows and knees are usual sites for this rare eruption. The yellowish nodules are smooth and non-scaly on the surface. Diabetes is almost always present.

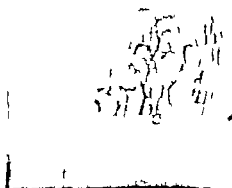


Fig. 264

Xanthoma Tuberosum



Fig. 269

Lupus Erythematosus Profunda

This is a rare form of the disease which in the absence of superficial lupus erythematosus lesions elsewhere could have to be differentiated from lupus vulgaris and nodulocutaneous syphilis.



Fig. 270

Lupus Erythematosus Profunda



Fig. 267

Lupus Vulgaris

There is some resemblance to psoriasis, but lamellar waxy scaling is absent. The plaques are slightly indurated and "apple-jelly" nodules can be demonstrated. Apart from the general appearance the histology would differentiate these lesions from necrobiosis lipoidica.



Fig. 268

Lupus Vulgaris

As in the previous example there is some resemblance to psoriasis, but the surface is warty and is not covered with waxy scales.



Fig. 272

Varicose Ulcer

An early lesion showing surrounding passive congestion.

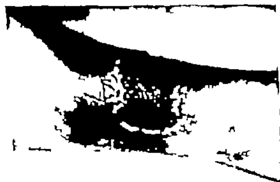


Fig. 273

Varicose Ulcer

A band type of ulcer. The surrounding skin is heavily pigmented, due to passive congestion.



FIG. 71
Syphilis
Ulcerated noduloculaneous lesions.



Fig. 276

Varicose Ulcer

The lesion has healed, leaving the skin and subcutaneous tissues in sclerosed condition.



Fig. 274

Varicose Ulcer

The surrounding skin is affected by staphylococcal folliculitis.



Fig. 75

Varicose Ulcer

The ulcer is superficial and there is a complicating infective eczema on the surrounding skin. The area is thickened, due to venous and lymph stasis.

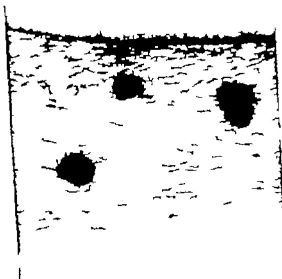


Fig. 279

Ecthyma

The eruption is deep-seated staphylococcal infection of the hair follicles. It may arise spontaneously or as a result of contact with hydrocarbon derivatives.



Fig. 280

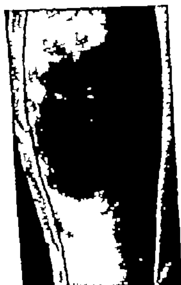


Fig. 281

Erythema Nodosum

The lesions are tender acute inflammatory nodules hich leave temporary bruised appearance as they disappear. The lesions are always bilateral and they do not ulcerate.



Fig 277

Keloid

The scar tissue is hypertrophic and in addition it enlarges at the periphery by the formation of finger-like extensions.



Fig 78

Keloid

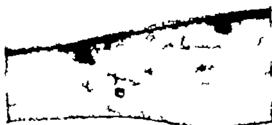


Fig. 284

Keratoma

Multiple lesions on leg. They may result from prolonged exposure to heat. A squamous cell carcinoma may develop at the base of keratoma.

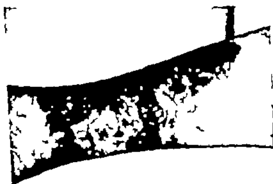


Fig. 285

Carcinoma

Multiple primary lesions of the leg situated on an old burn scar



FIG 282

Erythema Induratum

The lesion is a slowly developing, chronic, deep-seated inflammatory nodule which usually ulcerates. Recurrence is common.



FIG 283

Erythema Induratum

The lesions may be multiple and almost always affect the lower half of the posterior aspect of the legs. They may or may not be bilateral.



Fig. 288

Mycosis Fungoides

The tumours consist of accumulations of reticulum cells in the dermis and hypoderm. Ulceration is common. Spontaneous regression takes place after variable period, to be followed by fresh crops of tumours. The diagnosis depends on the histopathology



Fig. 289

Mycosis Fungoides

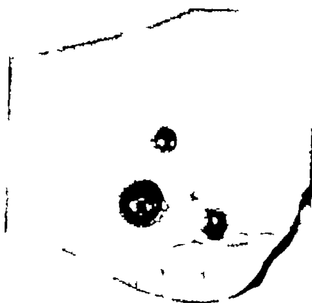


Fig. 286

Carcinoma

Secondary cutaneous deposits.

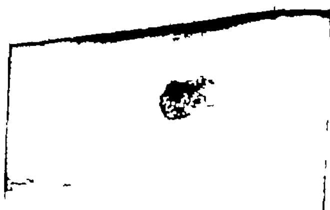


Fig. 287

Melanoma

The lesion is malignant in character but is only slightly pigmented. The diagnosis depends on histopathology.



Fig. 292

Hyperkeratotic Naevus

The malformation consists of a localised excess of keratin. The lesion resembles melanoma, but the black appearance is due to sulphur compounds in the keratin and not to melanin.



Fig. 293

Naevus Pigmentosus et Pilosus



FIG. 290

Dermato-fibro-sarcoma

This tumour is of low-grade malignancy. The leg is the usual site and the diagnosis depends on the histopathology

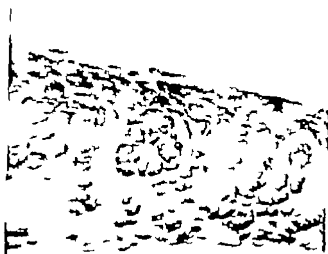


FIG. 291

Sarcoma

(Reticulum cell type)

The diagnosis depend on the histopathology



FIG. 295

Scabies

The lesions are scratched papules.

Figs. 295 to 302 show the eruption of scabies in varying degrees of profusion and secondary infection. The distribution of the lesions is, however, uniform.



FIG. 296

Scabies

Some degree of secondary infection is present. Note the involvement of the elbows.

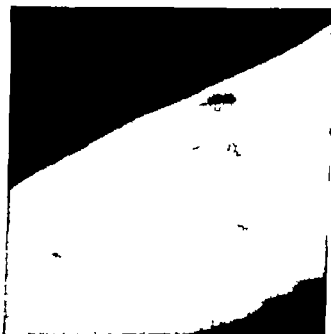


Fig 294

Glomus Tumour

Multiple lesions on upper arm. The usual sites for a glomus tumour are the fingers and toes. In this case the histopathology was necessary for diagnosis.



Fig. 299
Scabies



Fig. 300
Scabies
Detail of the impetigo on the abdomen.



FIG. 297

Scabies

As a result of scratching, impetigo and folliculitis have developed.



FIG. 298

Scabies

In Figs 296 to 298 a secondary impetigo has developed.



Fig. 303

Impetigo

Ruptured and unruptured bullae are seen. The condition is primary infection, and in this form is rarely met with on this site except in children. Usually it is complication of scabies.

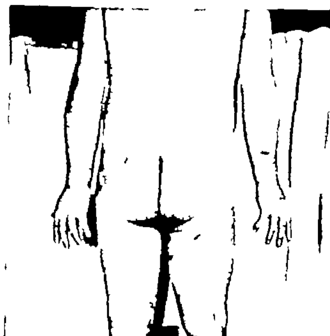


FIG. 301

Scabies

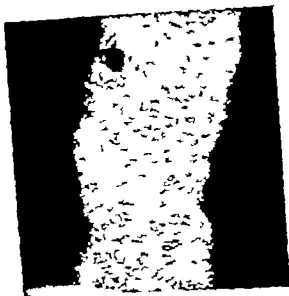
This illustration and that shown in Fig. 299 are of the same case There is a severe complicating impetigo on the anterior aspect of the trunk only



FIG. 302

Scabies

There is a profuse papular eruption on the trunk and limbs partly due to the parasite and partly to pyogenic infection.



Fɪɢ. 306

Pityriasis Rosea

The eruption is mainly confined to the trunk and the proximal parts of the limbs.



Fɪɢ. 307

Pityriasis Rosea

The lesions consist of small discrete erythematosquamous macules which are not infiltrated and only slightly scaly. These features differentiate it from papulosquamous syphilide and psoriasis. The roseolar syphilide is faint macular erythema which is not scaly. An erupting pityriasis rosea may resemble rubella, but the course of the eruptions will differentiate them.



FIG. 304
Eczema
A contact eczema due to dye in clothing

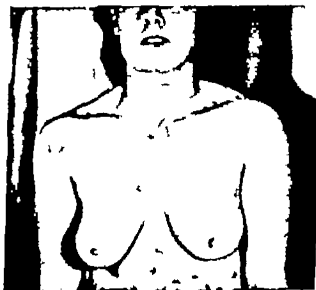


FIG. 305
Psoriasis
The eruption is composed of discrete non-indurated papules which show waxy lamellar scaling.

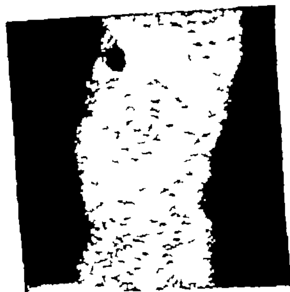


Fig. 306

Pityriasis Rosea

The eruption is usually confined *to the* trunk and the proximal parts of the limbs.



Fig. 307

Pityriasis Rosea

The lesions consist of small discrete erythematosquamous maculae which are not infiltrated and only slightly scaly. These features differentiate it from a papulosquamous syphilide and psoriasis. The roseolar syphilide is a faint macular erythema which is not scaly. An erupting pityriasis rosea may resemble rubella, but the course of the eruptions will differentiate them.

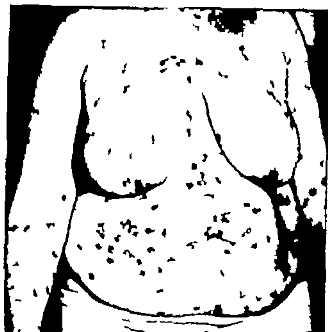


Fig 308

Papulosquamous Syphilide

The papules are indurated and surmounted by a single scale When removed this leaves a collarette of scale at the periphery of the lesion, and the exposed surface may become moist and even crusted.

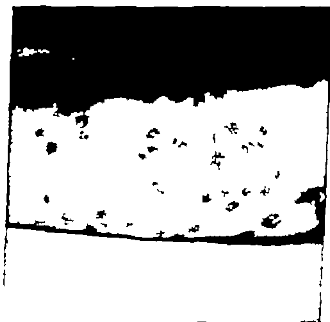


Fig 309

Papulosquamous Syphilide

The lesions are *indurated* squamous papules The scale often becomes detached from the summit of the papule, leaving a peripheral collarette of scale



Fig. 310

Lichen Planus

The eruption is composed of numerous slightly raised flat non-indurated and non-scaly papules.



Fig. 311

Lichen Planus

In this case the lesions are older and somewhat pigmented.



Fig. 312

Lichen Planus

The eruption is of long-standing, and it has become deeply pigmented and slightly warty on the surface.



Fig. 313

Lichen Nitidus

Compare lichen planus. The two conditions can be differentiated microscopically. The papules are smaller than those of lichen planus, but otherwise resemble them closely. In this case a plaque has developed through the coalescence of papules. The histopathology is typical and quite distinct from lichen planus.

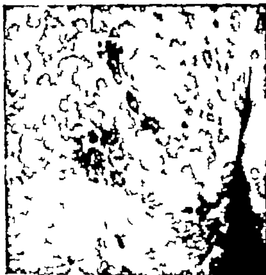


FIG. 314
Psoriasis

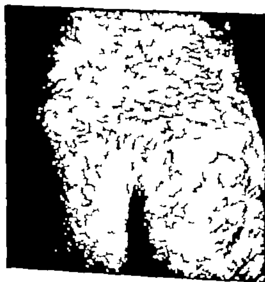


FIG. 315
Psoriasis



Fig. 316

Psoriasis

The silvery scales have been demonstrated by scratching (Tâche de bougie.)

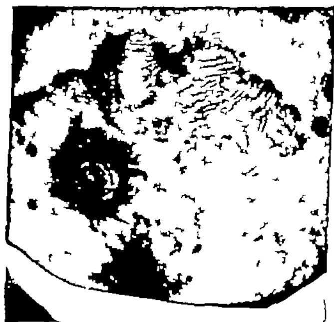


Fig. 317

Psoriasis

A large thickened plaque on which is situated a small squamous-celled carcinoma, due to prolonged ingestion of arsenic.



Fig. 318

Psoriasis

Either as result of confluence of papules or the central regression of plaques, annular lesions have been produced resembling tinea corporis.

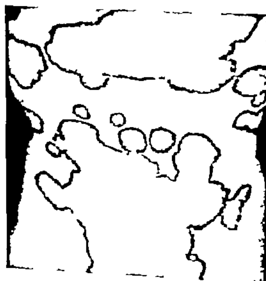


Fig. 319

Psoriasis

Annular form. Note that the ribbon-like lesions show typical psoriasis scaling.



Fig. 320

Tinea Corporis

The lesions bear a superficial resemblance to annular psoriasis.



Fig. 321

Tinea Corporis

The ringed edge is composed of papules and vesicles, and there are no waxy scales. Fungus elements can be demonstrated in scrapings from the edge.



Fig. 322

Erythema Annulare Centrifugum

This is a persistent slightly infiltrated erythema which spreads centrifugally in the form of rings. Compare the gyrate erythema of dermatitis herpetiformis. The lesion is an erythema, and neither vesicles, pustules, nor scaling are present.



Fig. 323

Herpes Zoster

This is a slight case. The grouping of the vesicles, their deep-seated character the unilateral distribution, and the attendant pain are diagnostic points.



Fig. 324
Herpes Zoster



Fig. 325
Herpes Zoster
This is a florid eruption. The unilateral character is well seen in the midline of the chest.



Fig. 326

Linear Hyperkeratotic Naevus

The lesion consists in an abnormality of keratin formation. The dark colour is due to the presence of sulphur compounds in the keratin and not to melanin.

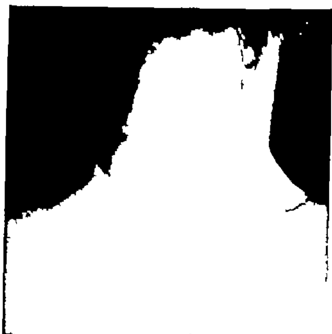


FIG 3_7
Urticaria

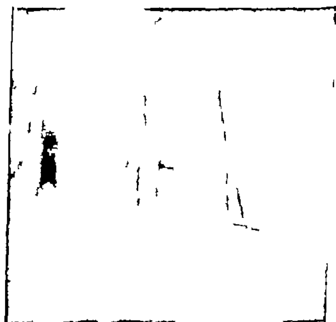


FIG 328
Dermographism



Fig. 329
Acne Vulgaris
Comedo and superficial pustular variety



Fig. 330

Oil Acne

A severe acneiform eruption in an adult, consisting of comedones, papules, and pustules, due to the action of mineral oil on the follicular orifices.

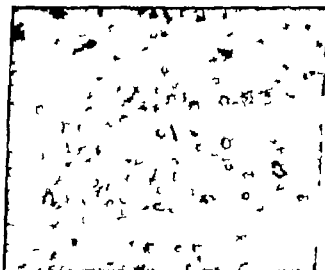


Fig. 331

Oil Acne



Fig. 332
Acne Vulgaris
Pustular variety



Fig. 333
Keloid
Following acne lesions.



Fig. 334

Necrobiosis Lipoidica

There is an irregularly shaped infiltrated plaque which has undergone some atrophy in the centre (See the same condition on the legs and hands.) In the differential diagnosis of this example lupus vulgaris and syphilis would have to be considered.



Fig. 335

Lupus Vulgaris

This is an extensive uncomplicated case of many years duration. Apple-jelly nodules are easily demonstrated.



Fig. 336

Nodulocutaneous Syphilide



FIG. 337

Nodulocutaneous Syphilide

A few active lesions are present and there is gross scarring.



FIG. 338

Nodulocutaneous Syphilide

The lesions bear some resemblance to multiple basal cell carcinomata. Their duration, combined with serology and histopathology clarify the diagnosis.



FIG. 339
Pityriasis Versicolor



FIG. 340
Pityriasis Versicolor

The eruption is due to the invasion of the stratum corneum by the microsporon furfur. The organism produces slight scaling, which is only evident on scratching. The affected skin has a light red or brown appearance and the condition may have to be differentiated from vitiligo. This is done by microscopic

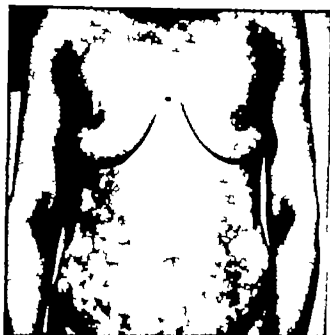


Fig. 341

Vitiligo

The condition consists in the development of depigmented patches, surrounded by areas of hyperpigmentation. If the latter is prominent as in this case the condition at first sight might suggest pityriasis versicolor Microscopic examination of surface scrapings will decide the point.



Fig. 342

Scleroderma

The affected area is depigmented, but the presence of sclerosis differentiates the lesion from that of vitiligo

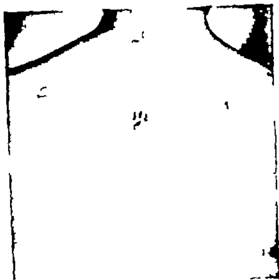


Fig. 343

Lichen Sclerosus et Atrophicans

Compare scleroderma. The histology differentiates this *condition from lichen planus atrophicans.* This condition may suggest scleroderma, but in it the lesions are not sclerosed. A scleroderma which has reached the atrophic stage, an atrophic lichen planus, or vitiligo are distinguished from it by histopathology



Fig. 344

Lichen Sclerosus et Atrophicans



FIG. 345

Pseudoxanthoma Elasticum

This is an atrophic change in the collagen and elastic tissue of the dermis which may develop rapidly. It is permanent and most commonly affects the upper part of the trunk. The change is diffuse and results in a slight alteration in the texture of the skin affected. It is to be differentiated from colloid pseudomilium *by the fact that the latter condition occurs as small papules. It might bear a* superficial resemblance to lichen sclerosus et atrophicans but is to be differentiated by its colour and histopathology.



FIG. 346

Pseudoxanthoma Elasticum

The lemon-yellow colour and the alteration in texture of the affected areas are seen.



Fig. 347

Molluscum Contagiosum

The side of the trunk is a common site. The contents of the lesions are easily expressed as a soft lobulated mass, and this, apart from the central umbilication, distinguishes the lesions from those of xanthoma, cysts, or lymphangioma circumscriptum.



Fig. 348

Cerebriform Naevus

The structure is fibromatous. Compare lymphangioma circumscriptum, molluscum contagiosum, and xanthoma.

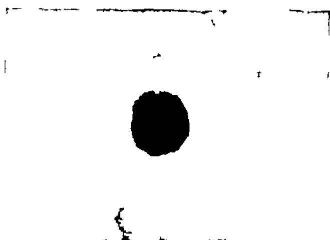


Fig. 349

Melanoma

A dark lesion of this type tends to show malignant change. This example is situated on the abdomen, a not uncommon site for malignant change to occur in such lesions.



Fig. 350

Verruca Senilis

The colour is due to hyperkeratosis. Such lesions very rarely tend towards malignant change.



Fig. 351

Neurofibromatosis

The lesions are pedunculated neurofibromata the skin overlying which tends to become hyperpigmented.



Fig. 352

Neurofibromatosis



Fig. 353
Superficial Cavernous Angioma



Fig. 354
Cavernous Angioma
The lesions are superficial, but are seldom so numerous as in this example



FIG. 355

Sclerosing Angioma

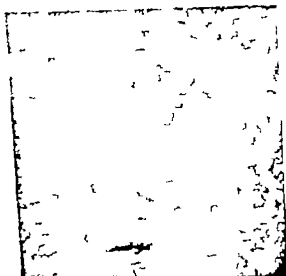


FIG. 356

Angiokeratoma Corporis Diffusum

It is extremely rare to find angiokeratoma in such profusion. The lesions are usually limited to the scrotum and digits.

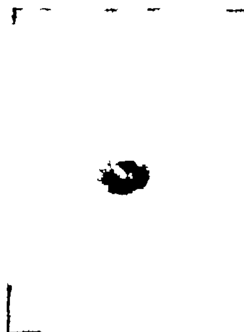


FIG. 357
Lymphangioma
Compare lymphangioma circumscriptum and granuloma pyogenicum.



FIG. 358
Naevus Pilosus et Pigmentosus



Fig. 359

Multiple Superficial Carcinomata

The lesions are basal cell in type. They may have to be differentiated from syphilitic lesions, and possibly psoriasis. The lesion on the right buttock is fungating basal cell carcinoma, quite different in appearance from the erythematosquamous lesions on the back.



Fig. 360

Multiple Carcinomata

The lesions are superficial carcinomatous nodules which have coalesced to form plaque. Compare psoriasis



FIG 361

Carcinoma Erythematoides

This appearance is due to the spread of cancer cells through the cutaneous lymphatic network from a tumour in the breast.



Fig. 362

Mycosis Fungoides

The eruption in this case takes the form of indurated erythematous plaques. These are produced by an infiltrate of reticulum cells in the dermis. The plaques are widely distributed over the body surface.

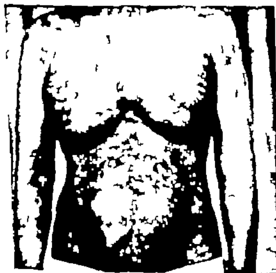


Fig. 363

Mycosis Fungoides

Indurated plaques are present over an extensive area. The diagnosis rests on the histopathology



Fig. 364

Mycosis Fungoides

In this example the infiltrate in the dermis is producing circumscribed tumours of varying size many of which ulcerate

In both the plaque and tumour form the eruptive elements disappear and recur The histopathology establishes the diagnosis.



Fig. 365

Sarcoma

This is a reticulum cell type. In contradistinction to mycosis fungoides the lesions do not tend to ulcerate or to disappear spontaneously They have to be differentiated from those of mycosis fungoides and leukæmia.



Fig. 366

Eczema

Flexural infective type. Note the symmetry of the eruption on either side of the submammary fold and the outlying nummular satellite lesions.



Fig. 367

Eczema

Post-traumatic infective eczema follow [illegible]

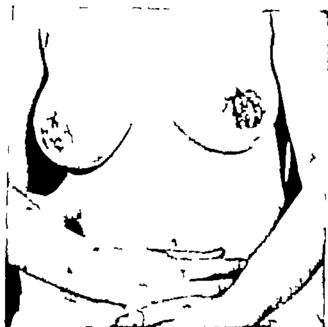


Fig. 368

Eczema

Post-traumatic infective eczema, due to scratching in scabies.

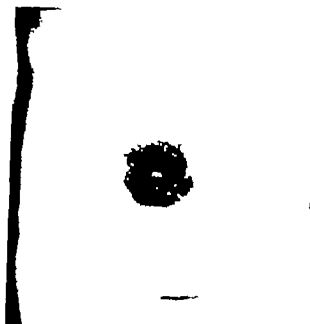


Fig. 369

Carcinoma

Paget's disease, originating the mammary duct and breast tissue. The skin lesion con ist of aggregated cutaneous nodules forming a plaque which becomes eroded on the surface The epidermis has been invaded by duct carcinoma cells.



FIG. 370

Carcinoma

Paget's disease. The skin lesion consists of coalesced intra-epidermal carcinomatous nodules the surface of which is eroded.



FIG. 371

Mycosis Fungoides



Fig. 372

Acne Conglobata

Indolent abscesses and bridged scar formation are present. In addition the condition is usually present on the back, buttocks, scalp, and face.



Fig. 373

Hidrosadenitis

Acute recurrent abscess formation involving the sweat glands.



Fig. 374

Fox Fordyce disease

This is papular eruption due to the presence of an inflammatory infiltrate in the region of the apocrine sweat glands. It is persistent and extremely itchy It may have to be differentiated from lichen planus.

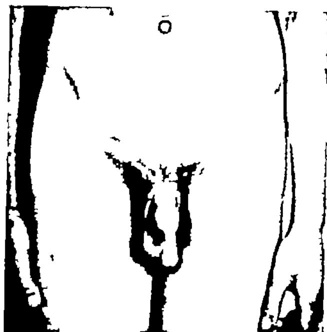


FIG 375

Flexural Infective Eczema

Note the symmetry of the lesions on either side of the inguinal fold. In tinea cruris the upper inner aspect of the thigh is mainly involved

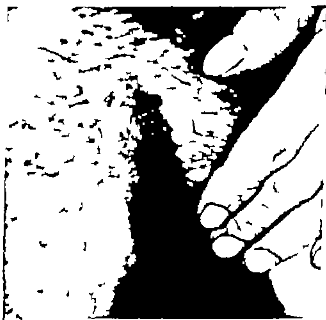


FIG. 376

Tinea Cruris



Fig. 377

Hidradenitis

The condition is similar to that which is more commonly seen in the axilla. In this case, in addition to the deep sweat gland abscess involving the labium, there is a secondary folliculitis on the pubes.



Fig. 378

Eczema

Flexural infective type. The various folds in the area are affected in ... fashion



FIG. 379

Moniliasis



FIG. 380

Psoriasis

Large waxy scales are present on the thigh lesions but are much less in evidence in the neighbourhood of the fold of the groin. Here the lesions might suggest flexural infective eczema, but the fold is not involved symmetrically on either side.



FIG. 381
Syphilis
Double chancre.



FIG. 382
Syphilis
Papulosquamous syphilide. The lesions might have to be differentiated from those of lichen planus.



Fig. 383

Syphilis

Papulosquamous syphilide, "mucous patch" variety



Fig. 384

Lichen Planus

The lesions might have to be differentiated from those of a papulosquamous syphilide



FIG. 385

Verruca Vulgaris



FIG. 386

Carcinoma

The tumour is squamous-celled type.



Fig 387

Angiokeratoma

The lesions consist of small capillary angiomata surmounted by a small mass of keratin. They also occur on the toes, and very occasionally as a profuse eruption on the trunk and limbs.

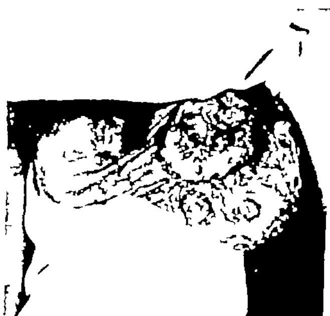


Fig 388

Carcinoma



Fig. 389

Eczema

Flexural infective type. The symmetrical involvement of *the fold, the sharply defined margin*, and the fissure at the depth of the fold are apparent.



Fig. 390

Lymphangioma Circumscriptum

The lesions exude plasma when punctured.

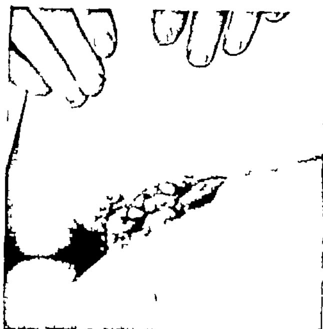


Fig. 391

Verruca Vulgaris (Condyloma Acuminatum)

The lesions are the same type of common wart which affects other areas of the skin but which tend to be larger and more vascular when they develop on the natal fold and genital areas. They have to be differentiated from moist syphilitic papules.



Fig. 392

Syphilis

Papulosquamous lesions (condylomata lata). The lesions are papules which tend to be larger than similar syphilitic lesions on other areas of the body. They have to be differentiated from the common wart, which may also affect the perianal region.



Fig. 393

Acne Conglobata

The condition is chronic deep-seated pyoderma which affects the buttocks, shoulders, axillae, face, and scalp. It has some resemblance to severe acne vulgaris, but makes its appearance at later age period.



Fig 394

Papulosquamous Syphilide

This syphilitic eruption may bear a superficial resemblance to guttate psoriasis.



Fig 395

Papulopustular Syphilide

The lesions are indurated on palpation, and this differentiates them from those of guttate psoriasis.

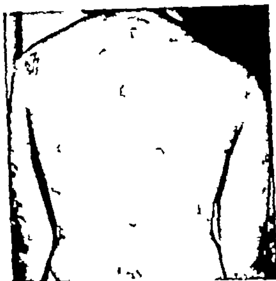


Fig. 396

Psoriasis

The eruption is in an early stage and consists of non-indurated squamous papules. *The absence of induration differentiates them from syphilitic papules.*



Fig. 397

Pityriasis Rubra Pilaris

The eruption consists of non-indurated follicular papules hich give the surface rough texture.

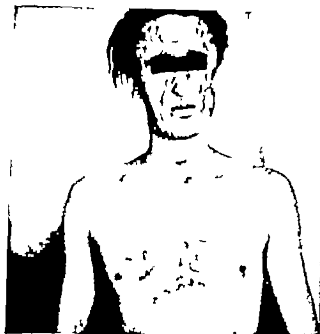
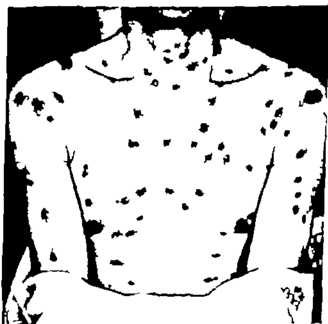


Fig. 394

Papulosquamous Syphilide

This syphilitic eruption may bear a superficial resemblance to guttate psoriasis.



F 395

Papulopustular Syphilide

The lesions are indurated on palpation, and this differentiates them from those of guttate psoriasis.



FIG. 400

Pityriasis Rubra Pilaris

The eruption has become completely confluent and resembles generalised psoriasis, but scaling is much less in evidence. In this stage pityriasis rubra pilaris may have to be differentiated not only from psoriasis but from generalised lichen planus, generalised eczema, drug eruptions, and the reticuloses.

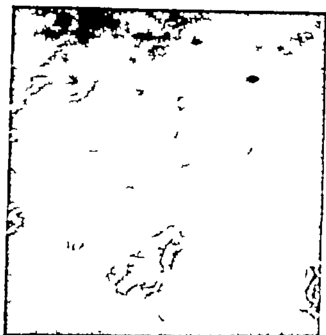


FIG 398

Pityriasis Rubra Pilaris

The papules have become confluent, producing large areas of erythroderma, but here and there clear areas have been left which still show isolated papules.



FIG 399

Pityriasis Rubra Pilaris

The eruption is becoming confluent nd present net work of erythematous plaques.



FIG. 403

Lichen Planus

The eruption is becoming generalised and in places it is confluent. Individual papules and groups of papules are however still to be made out on the midline. Scaling is conspicuous by its absence.



Fig. 401

Psoriasis

The eruption is generalised and confluent but still shows the lamellar scaling of psoriasis.

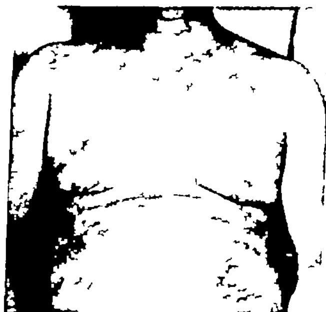


Fig. 402

Lichen Planus

A generalised case of long standing. The lesions have become cyanotic and pigmented.

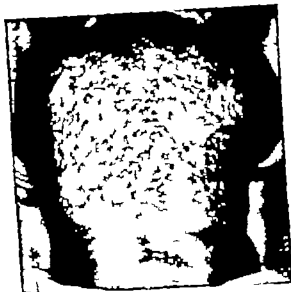


Fig. 405

Eczema

A generalised papulovesicular eczema secondary to an infective eczema of the leg



Fig. 406

Lichen Planus

The papular eruption is becoming confluent with the formation of [illegible] plaques. The outlines of individual papules may still be apparent in the plaques. Vesiculation does not occur and the condition of the eruption remains constant over long periods in contrast to eczema, which may alternate between wet and dry phase



FIG 404

Eczema

A commencing generalised eruption of papulovesicles which is secondary to a primary area of infective eczema on the leg.



Fig. 405

Eczema

A generalised papulovesicular eczema secondary to an infective eczema of the leg.



Fig. 406

Lichen Planus

The papular eruption becoming confluent with the formation of erythrodermatous plaques. The outlines of individual papules may still be apparent in the plaques. Vesiculation does not occur and the condition of the eruption remains constant over long periods in contrast to eczema, which may alternate between a wet to a dry phase.



Fig. 407

Eczema

The entire body surface is involved in an eczema reaction. The primary area of eczema was an infective eczema of the leg and generalisation developed suddenly presumably as a result of absorption of an allergen from the primary area



Fig. 408

Eczema

This is generalized infective eczema, due to slow extension from areas of infective eczema affecting all the body folds. Eczema may become generalized rapidly as result of absorption from primary area of contact or infective eczema, or more slowly as a result of the slow extension and ultimate confluence of multiple patches. It may also be produced by the internal administration of the heavy metals. In its dry scaly phase generalized eczema may have to be differentiated from generalized psoriasis, generalized pityriasis rubra pilaris, generalized lichen planus, and the reticuloses. The histopathology and haematology of the case may be necessary for diagnosis.



Fig. 409

Eczema

A generalised eczema secondary to a contact eczema on the hands.

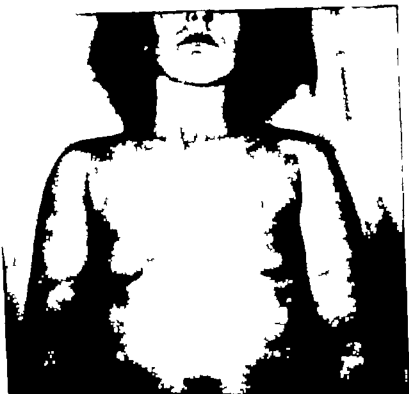


FIG. 410

Eczema

The same case as Fig. 409



Fig. 411
Eczema
The face lesions in a case of generalised infective eczema.



Fig. 412
Eczema
The same case as is shown in Fig. 411



Fig. 413

Eczema

Figs. 411 to 413 show generalised eczema secondary to an infective eczema of the ankle. The generalisation was of sudden onset.



Fig. 414

Besnier's Prurigo

The infective eczema on the breasts and the papular eruption on the chest might suggest scabies. The presence of lichenification and the history reveal the nature of the condition.



FIG 415

Besnier's Prurigo

Note the lichenification with superimposed papulo-vesicles on the popliteal areas.



FIG. 416

Besnier's Prurigo

An acute exacerbation of the eczema reaction on lichenified skin.



FIG. 417

Eczema

A commencing Besnier prurigo. This eczema has followed an infantile eczema and in due course will become Besnier's prurigo.



Fig. 418

Dermatitis Herpetiformis

Juvenile form. A subepidermal bullous eruption. A very recent eruption might suggest varicella but the course of the disease would clarify the diagnosis. The histopathology of the bullae in the two conditions is quite distinct.



Fig. 419

Dermatitis Herpetiformis

Juvenile form. A profuse eruption of subepidermal bullae showing a herpetiform grouping of the lesions. A similar condition can be produced by bromides or iodides.



FIG. 420

Dermatitis Herpetiformis

Juvenile form. Bunched tense subepidermal bullæ. Note that the bullæ are situated on uninflamed skin. This feature was formerly regarded as favouring diagnosis of pemphigus vulgaris, but it has no such significance.



FIG. 421

Dermatitis Herpetiformis

Juvenile form. The eruption is entirely composed of persistent gyrate erythematous plaques and might suggest diagnosis of erythema gyratum centrifugum. A previous history of bullæ, or their subsequent appearance, would clarify the diagnosis.



Fig. 422

Dermatitis Herpetiformis

Juvenile form. Gyrate persistent erythema with superimposed subepidermal bullæ. The eruption might suggest tinea corporis and require a microscopic examination for fungus elements.

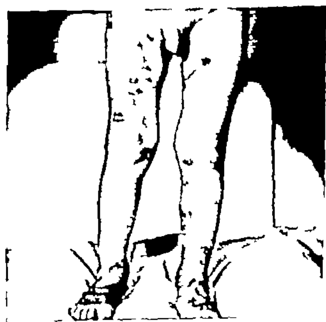


Fig. 423

Dermatitis Herpetiformis

To show a common distribution of erythematous plaques and subepidermal bullæ when the disease occurs in children. The eruption illustrated might suggest an eczema, but the essential element are erythematous plaques and bullæ



Fig. 424

Dermatitis Herpetiformis

The eruption consists of mixture of grouped subepidermal bullæ and infiltrated erythematous plaques with bullæ situated on them.



Fig. 425

Dermatitis Herpetiformis

The patient is aged 65 years and gravely ill. Recovery subsequently took place. The appearance of the eruption, the absence of gyrate erythema, and the gravity of the constitutional symptoms suggested diagnosis of pemphigus vulgaris, but the bullæ were subepidermal.



Fig. 426

Dermatitis Herpetiformis

. a previous attack the eruption was a purely subepidermal bullous one. In the resent attack the main feature is infiltrated gyrate erythema with few bullæ The attack proved fatal.



Fig. 427
Dermatitis Herpetiformis
This is the same case as is shown in Fig. 426



FIG. 428
Dermatitis Herpetiformis



FIG. 429
Dermatitis Herpetiformis

Figs. 428 and 429 show a generalised erythematobullous eruption, but on the left shoulder a portion of the eruption shows a remarkable resemblance to herpes zoster. It will be noted, however, that the zoster-like patch crosses the middle line.



Fig. 430

Dermatitis Herpetiformis

This case shows lichenoid papules which have developed at the site of pre-existing subepidermal bullae.



Fig. 431

Dermatitis Herpetiformis

To show the upper surface of the dermis, which has been exposed by the removal of the epidermal roof of large subepidermal bullae. The appearance suggests pemphigus vulgaris rather than dermatitis herpetiformis, but the bullae are subepidermal. The patient recovered.



FIG. 432

Dermatitis Herpetiformis

The eruption is composed uniformly of subepidermal bullæ. The patient is aged 70 years and succumbed to the attack.



FIG. 433

Dermatitis Herpetiformis

The patient is aged 63 acutely ill, but recovered. The bullæ are subepidermal.



Fig. 434

Pemphigus Vulgaris

A sparse eruption of intra-epidermal bullæ, with a complete absence of erythema.



Fig. 435

Pemphigus Vulgaris

This shows the details of the intra-epidermal bullæ. The individual lesions and groups of lesions are indistinguishable clinically from those of dermatitis herpetiformis.



Fig 436

Dermatitis Herpetiformis

The patient is aged 74 and later died from the disease. The eruption is uniformly bullous, but the bullæ are subepidermal. The histopathology is the only criterion on which to differentiate the disease from pemphigus.



Fig 437

Pemphigus Vulgaris

The eruption is purely bullous in character, the bullæ show grouping but they are intra-epidermal The disease has responded favourably to aureomycin therapy



Fig. 438

Pemphigus Vulgaris

This is profuse eruption of intra-epidermal bullæ. A similar clinical appearance can be presented by dermatitis herpetiformis. The patient succumbed to the disease.



Fig. 439

Pemphigus Vulgaris

The bullæ are intra-epidermal, and large areas of the epidermal rete mucosum are exposed. A [illegible]



FIG 440

Pemphigus Foliaceus

The eruption consists of flaccid subcorneal bullæ It has been present for three months. The distribution suggests lupus erythematosus, and this resemblance is accentuated when crusts are allowed to accumulate.



FIG 441

Pemphigus Foliaceus

The same case as in Fig. 440 the eruption has been present for three months. The eruption in this phase has been entitled the Senear Usher syndrome The distribution is that of seborrhœa corporis, but the lesions are subcorneal bullæ



FIG. 442

Pemphigus Foliaceus

This is the same case as in Figs. 440 and 441 and is of three months' duration. Note the involvement of the scalp by flaccid bullae.



FIG. 443

Pemphigus Foliaceus

The same case as in Fig. 440 nine months from its onset. The bullae are more profuse.



Fig 444

Pemphigus Foliaceus

This figure shows the detail of the eruption seen in Fig. 443 The lesion is a subcorneal bulla



Fig 445

Pemphigus Foliaceus

After eighteen months the eruption is now confluent and the complete clinical picture of pemphigus foliaceus is presented. Figs. 440 to 445 illustrated the gradual development of pemphigus foliaceus



FIG. 446

Pemphigus Foliaceus

This shows generalised eruption of subcorneal bullae the gyrate and crescentic configuration of the lesions is characteristic.



Fig. 447

Pemphigus Foliaceus

This case has persisted for nine years. The eruption is past the confluent stage and is gradually becoming less in amount.



Fig. 448

Pemphigus Foliaceus

This shows the details of the subcorneal bullæ of the case shown in Fig. 447



Fig. 449

Pemphigus Foliaceus

This is the same case as is show in Fig. 447. The lesions are now discrete and show crescentic outlines, hich is typical.



Fig. 450

Pemphigus Foliaceus

The eruption in this case has gone through the stages show in the preceding figures. The formation of subcorneal bullæ has ceased and the hole skin surface is [illegible]



Fig 451

Dermatomyositis

The eruption in this case bears a superficial resemblance to poikiloderma.



Fig 452

Dermatomyositis

The eruption is erythematous and telangiectatic.



Fig. 453

Dermatomyositis

Showing oedema and telangiectatic erythema of the face.

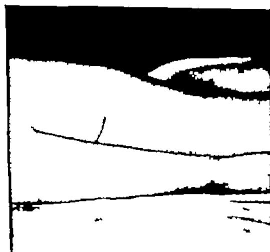


Fig. 454

Dermatomyositis



FIG. 455
Dermatomyositis
The eruption consists of a telangiectatic streaked erythema.



FIG. 456
Dermatomyositis
Showing œdema and erythema, there being some resemblance to acute lupus erythematosus.



Fig. 457
Poikiloderma (Atrophicans Vasculare)



Fig. 458
Poikiloderma (Atrophicans Vasculare)

Note telangiectatic reticulate erythema, atrophy of the skin, and patchy pigmentation. The eruption was not associated with myositis.



Fig 459

Lupus Erythematosus

The eruption commenced as discrete discoid lesions on the face. It suddenly became generalised as a persistent erythema and severe constitutional symptoms developed.



Fig 460

Stevens-Johnson Syndrome

The eruption suggests a severe form of erythema multiforme, but the individual erythematous plaques and macules are atypical. It also suggests a drug eruption



FIG. 461

Stevens-Johnson Syndrome



FIG. 46.

Stevens-Johnson Syndrome

The involvement of the mucous membranes is constant feature.



FIG. 463
Herpes Zoster Varicellosus

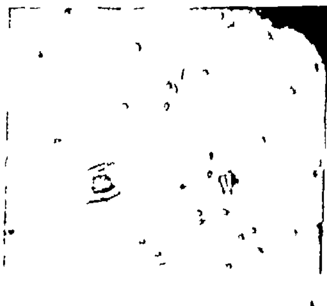
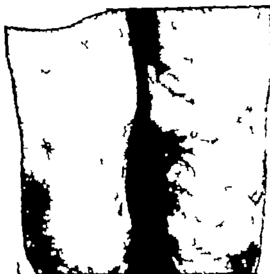


FIG. 464
Herpes Zoster Varicellosus

Figs. 463 and 464 represent a severe attack of herpes zoster followed shortly after the appearance of the zoster eruption by a generalised varicelliform eruption the details of which are shown Fig. 464



A



B

Fig. 465

Acrodermatitis Chronica Atrophicans

The atrophy bears some resemblance to poikiloderma but is generalised. Areas of sclerosis alternate with patches of atrophy hyperpigmentation, leucoderma, and telangiectasia.



FIG. 466
Urticaria Pigmentosa



FIG. 467
Urticaria Pigmentosa
The lesions consist of persistent pigmented macules which show a transient urticarial reaction when rubbed.



Fig. 468
Darier's Disease



Fig. 469
Darier's Disease



Fig. 470

Darier's Disease



Fig. 471

Darier's Disease

When once developed this condition remains permanent with variations in degree. It consists of isolated hyperkeratotic areas which may remain discrete or become confluent and which have a typical histology. The case illustrated is a severe one and the condition may be much less extensive.



Fig. 472
Ichthyosis



Fig. 473
Ichthyosis

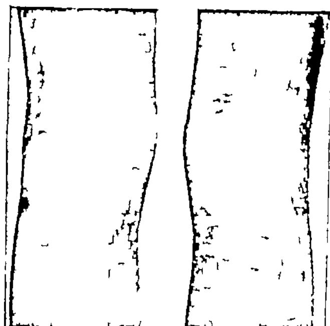


Fig. 474
Ichthyosis
The epidermal malformation seldom involves the flexures. Here the skin of the popliteal area is normal. This is a complete reversal of what is found in Besnier's prurigo



Fig. 475
Ichthyosis
Severe ichthyosis associated with extreme hyperkeratosis. There are all gradations of ichthyosis ranging from slight dryness and roughness of the skin to the extreme hyperkeratosis shown in this case

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